S. No. 2
0M—5-43
v. 5-17-39
I X36671

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 15 1947
Registration District No. 37

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 29986
Registrar's No. 1866

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town PINE LAWN (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4002 Council Grove Ave / (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town Pine Lawn, (If outside city or town limits, write "RURAL")
(d) Street No. 4002- Council Grove Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME JOHN J SOISSON
3. (b) If veteran, name war " No
3. (c) Social Security No. 497-03-9019
4. Sex MALE
5. Color or race WHT.
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife LENA SOISSON
6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased APRIL (Month) 2 (Day) 1882 (Year)
8. AGE: Years 65 Months 4 Days 23 If less than one day ..... hr. ..... min.
9. Birthplace Unknown (City, town, or county) Penn. / (State or foreign country)
10. Usual occupation Carpenter
11. Industry or business .....
MOTHER FATHER
12. Name Unknown
13. Birthplace " (City, town, or county) " (State or foreign country)
14. Maiden name "
15. Birthplace " (City, town, or county) " (State or foreign country)
16. (a) Informant Geo. Soisson Son
(b) Address 4002 Council Grove
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8/27/47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Mark Tierney
(b) Address 6190 W. Florissant Ave
19. (a) 8-29-47 (Date received local registrar) (b) Cecil A. Shapiro (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 24th, 25th year 1947 hour 12:30 minute A. M.
21. I hereby certify that I attended the deceased from Aug. 21St, 1947 to Aug-24th, 1947 that I last saw him alive on Aug-24th- 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Apoplexy Rt. Post Area third Convolution cerebrum	4Da.
Due to: While at work-caused by activity and extreme heat.	
Due to: Hemiplegia complete left	4-Da.
Other conditions: Hypertension- arterio-sclerosis.	

Major findings: Of operations No. 830
Of autopsy No.

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury .....

Signature Jack B Tierney M.D. (M. D. or other)
Address 3734- Jennings Road Date signed 8-26-1947

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Mark Iverson

Licensed Embalmer No. 4174

P. O. Address 6100 W. Flamingo Rd

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.